WISCONSIN FAMILY MEDICAID, BADGERCARE, AND FAMILY PLANNING WAIVER PROGRAM INSTRUCTIONS FOR APPLICATION AND REVIEW

This application is to be used by families with children under age 19 and pregnant women who are applying for Wisconsin Medicaid or BadgerCare, and for single women between the ages of 15 and 44 who are applying for the Family Planning Waiver Program. This is not an application for FoodShare Wisconsin, child care or Wisconsin Works (W-2). If you are interested in applying for these assistance programs you must contact your local county/tribal social or human services agency or your W-2 agency. These programs provide single people or families help with the cost of food, the cost of child care, or finding a job as part of W-2.

If you need help filling out this application or wish to answer the questions in person or over the telephone, contact your local county/tribal social or human services agency. For other questions regarding Wisconsin Medicaid, BadgerCare, the Family Planning Waiver Program or FoodShare Wisconsin, please call Recipient Services at 1-800-362-3002. Information is also available on the Department of Health and Family Services' web site ***at:*** http://www.dhfs.wisconsin.gov/medicaid/.

If you have a disability and need to access the instructions and application in an alternate format or need it translated to another language, please contact Recipient Services at 1-800-362-3002 (toll free). All translation services and translated information are free of charge.

HOW TO USE THIS FORM

1. Read these instructions and important information completely before completing the application.
2. Print clearly. Use blue or black ink.
3. Fill out the application completely. Answer all the questions. There may be a delay in Medicaid, BadgerCare or the Family Planning Waiver Program benefits if the application is not complete. If your application is not complete, your county/tribal social or human service agency will contact you for more information.
4. Do not write in the shaded sections.
5. Enter information about all the people that live in your household. If you need more space, add a second sheet.
6. If you are pregnant, please include (with your application) a signed and dated note from your doctor or another health care professional which states that you are pregnant, identifies your expected due date and whether you are expecting multiple births.
7. Keep the Important Information (pages 2 through 4) and the Medicaid Change Report form (HCF 10137) at the back of the application packet for future use.
8. You may authorize a representative to apply for you. Contact Recipient Services at 1-800-362-3002 to have a form sent to you or visit our web site at http://dhfs.wisconsin.gov/medicaid1/applications.htm. This form authorizes a representative to complete and sign the application for you. A legal guardian, conservator, power of attorney or durable power of attorney may apply for an individual without separate authorization by the individual.

CODE KEYS

The following are the codes that are used in section II of the application.

Marital Status
Enter the code in the space provided that best describes each household member's marital status.

A	=	Annulled
D	=	Divorced
LS	=	Legally Separated
M	=	Married
N	=	Never Married
S	=	Single
W	=	Widowed

Race / Ethnic Background (This information is voluntary and will not be used to determine eligibility.)

A	=	Asian
B	=	Black
H	=	Hispanic origin
I	=	American Indian/Alaskan Native
P	=	Native Hawaiian or Pacific Islander
S	=	Southeast Asian
W	=	White

IMPORTANT INFORMATION

The following is important information regarding Wisconsin Medicaid, BadgerCare and Family Planning Waiver Program eligibility.

- Your application date is the date your application is received by your county/tribal social or human services agency. The application must include at least your name, address and signature. A decision regarding your eligibility for Medicaid, BadgerCare or Family Planning Waiver Program will be mailed to you within 30 days of the application date. Unsigned forms will not be processed and will be returned.

  It is important to apply as soon as possible. Eligibility for benefits is based on your application date. If you are eligible, you may be able to get Medicaid benefits for up to three months before your application date if all the needed information is collected for the prior months and you are determined to have been eligible in those months. If you want help paying for health care for any of the three months prior to your application date (backdating), make sure you checked the "Yes" box on the application where the backdating question is asked and complete the Request for Medicaid Backdating form (HCF 10100B) in this packet.

  There is no backdating for BadgerCare or the Family Planning Waiver Program. Eligibility for these programs can begin no earlier than the first of the month in which you apply.

- Your rights and responsibilities are provided in the *Wisconsin Medicaid Program – Eligibility and Benefits* brochure (PHC 10025). If you do not have a brochure, you may obtain one at your local county/tribal social or human services department or by calling Recipient Services at 1-800-362-3002. If you have any questions about your rights and responsibilities contact your local county/tribal social or human services agency or Recipient Services at 1-800-362-3002.

- If you are found eligible for Medicaid, BadgerCare, or the Family Planning Waiver Program you will need to complete a review every 12 months to determine your continued eligibility.

PERSONAL INFORMATION

Under Wisconsin Statute section 49.45 (4), personally identifiable information is kept confidential and is only used for the direct administration of Wisconsin Medicaid, BadgerCare and the Family Planning Waiver Program.

SOCIAL SECURITY NUMBER

If someone in your household is not applying for Medicaid, BadgerCare or the Family Planning Waiver Program you do not need to provide Social Security Number (SSN) information for that person. Providing or applying for an SSN is voluntary; however any person who wants Wisconsin Medicaid, BadgerCare or the Family Planning Waiver Program, but does not want to provide their SSN or apply for one will not be eligible for benefits, pursuant to Wisconsin Statutes section 49.82(2).

If you are applying only for emergency services because of your immigration status, you do not need to provide SSN information.

SSN information will be used for administration of Wisconsin Medicaid, BadgerCare and the Family Planning Waiver Program. Your SSN permits a computer check of your information with government agencies such as the Internal Revenue Service (IRS), Social Security Administration and the Department of Workforce Development. In addition, the Department will match your name and SSN with information provided by health insurance carriers to determine if you have other health insurance.

Your SSN will not be shared with the United States Citizenship and Immigration Services (USCIS).

REPORTING CHANGES

Report to the agency **within 10 days:**

- Any changes in **income** of any member of your household, AND
- Any other change in the information you have given on your application that is required to be reported on the Medicaid Change Report form.

Note: For the Family Planning Waiver program, only changes in residency need to be reported within 10 days.

Changes can be reported using the Medicaid Change Report form (HCF 10137), which can be found in this application packet. Keep this form for future use. Do not send it with your application.

CITIZENSHIP

All persons living in your household and applying for aid must be citizens or nationals of the United States or be in a satisfactory immigration status. The immigration status of any person in your household who is applying for benefits will be verified with the United States Citizenship and Immigration Services (USCIS). Information from USCIS may affect your household's eligibility and amount of benefits. Immigration status will not be verified with USCIS for people in your household who are not applying for assistance.

CHILD SUPPORT COOPERATION

In some situations, you must cooperate with the Child Support Agency to establish paternity, by helping to locate absent parents, legally naming the absent parent and/or enforcing child support orders if you are requesting Medicaid, BadgerCare or the Family Planning Waiver Program. Failure to cooperate with the Child Support Agency without good cause may result in termination or a reduction in benefits for adults who are not pregnant.

OTHER MEDICAL COVERAGE

As a condition of Medicaid and BadgerCare eligibility, you must report to the agency any third party who may be liable to pay for medical care for yourself and your family. You must cooperate by giving information as requested. This also includes any insurance that may be available through an absent parent or an employer's group health insurance.

RECOVERY OF MEDICAID

Wisconsin state law provides for the recovery of certain Medicaid and BadgerCare benefits you receive in error. The law also provides for the recovery of certain Medicaid benefits you receive after you turn 55 years old and all Medicaid benefits you receive while you are a resident in a nursing home and while you are an inpatient in a hospital for 30 days or more. Under limited circumstances, a lien may be placed on your home for benefits you receive while you are residing in a nursing home if you are unlikely to return home and your spouse (or minor/disabled son or daughter) does not live in the home.

RIGHTS AND RESPONSIBILITIES

Your signature on the application means that you understand and acknowledge that the county/tribal social or human services agency, W-2 agency and the state Department of Health and Family Services is authorized to request any information that is appropriate and necessary for the proper administration of Wisconsin Medicaid, BadgerCare and the Family Planning Waiver Program authorized under Wisconsin law. Any persons, including financial institutions, credit reporting agencies, or educational institutions are authorized to release this information, unless access to the information is prohibited or restricted by law.

FAIR HEARING

You have the right to appeal any action taken concerning your Medicaid, BadgerCare, or Family Planning Waiver Program application or on-going benefits that you do not agree with by requesting a Fair Hearing. You may request a Fair Hearing by writing to:

Wisconsin Department of Administration
Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

or by calling: Telephone (608) 266-7709

The "Request for Fair Hearing" form can also be found on the Division of Hearings and Appeals web site at http://dha.state.wi.us/home/.

You may also contact the office where you applied and ask for assistance with filing a Fair Hearing request. You can refer to the *Wisconsin Medicaid Program – Eligibility and Benefits* brochure (PHC 10025) or your Notice of Decision for more information on the fair hearing process.

The Department of Health and Family Services (DHFS) is an equal opportunity employer and service provider. For civil rights questions, call (608) 266-3465 (voice) or (608) 266-2555 (TTY).

To file a complaint of discrimination contact either the:

Wisconsin Department of Health and Family Services (DHFS)
Affirmative Action and Civil Rights Compliance Office
1 W. Wilson, Room 555
Madison, WI 53707-7850
Telephone: (608) 266-9372 (Voice); (608) 266-5555 (TTY)
Fax: (608) 267-2147

OR

U.S. Department of Health and Human Services
Office for Civil Rights – Region V
233 N. Michigan Avenue
Suite 240
Chicago, IL 60601
Telephone: (312) 886-5077 (voice) or (312) 353-5693 (TTY)

CHECKLIST

☐ Is the application complete?

☐ If you are not a U.S. citizen, did you include a copy of both sides of your immigration status documents?

☐ If you are pregnant, did you include a signed and dated note from a doctor or other health care professional saying that you are pregnant and stating your due date?

☐ Did you read the Rights and Responsibilities Section?

☐ Did you sign and date the application form?

☐ Did you include the Authorized Representative Form if you are acting on behalf of an applicant?

☐ Did you include the Request for Medicaid Backdating, if you are requesting that your coverage be backdated?

☐ Did you keep the Instructions and Important Information (pages 2 through 4) and the Medicaid Change Report (HCF 10137), for future use?

Send the completed application to your local county/tribal social or human services agency. Addresses for county/tribal agencies can be found at http://dhfs.wisconsin.gov/em/imagencies/index.htm or by contacting Recipient Services at 1-800-362-3002. Keep the Important Information (pages 2 - 4) and the Medicaid Change Report (HCF 10137), for future use.

OTHER PROGRAM INFORMATION
If you are interested in services for veterans, call 1-800-947-8347 (WIS-VETS), or contact your county Veteran Service Officer.

For information about the Women, Infants, and Children (WIC) Nutrition Program, call 1-800-722-2295.

For information about services for women, children and families, contact the Wisconsin Maternal Child Health Hotline at 1-800-722-2295.

ACCESS TO ELIGIBILITY SUPPORT SERVICES FOR HEALTH AND NUTRITION (ACCESS)
To find out if you may be eligible for health and nutrition programs, visit the state of Wisconsin's web site at http://access.wisconsin.gov/access/.

This online screening tool will take you about 15 minutes to use. We'll ask you to tell us general information about yourself and the people in your home, the money you get from a job or other places, your housing costs and a few other bills. What you tell us will stay private and secure.

When you are finished, ACCESS will let you know about health and nutrition programs you and the people in your home might be eligible for. It will also explain how to apply for these programs. On the last page, you will be able to print out a summary of all the information ACCESS provides. ACCESS does not keep any identifying information after you leave the web site.

This screening tool is optional. You do not have to use the screening tool prior to applying for Wisconsin Medicaid.

STATE OF WISCONSIN
DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 10100 (Rev. 06/05)

APP

WISCONSIN FAMILY MEDICAID, BADGERCARE, AND FAMILY PLANNING WAIVER PROGRAM APPLICATION

Use blue or black ink. Do not write in the shaded areas. If more space is needed, use an additional sheet of paper. Write all dates in the MM/DD/YY format (Example 04/02/58). Keep the Important Information (pages 2 through 4) and the Medicaid Change Report form for future use.

SECTION I – CLIENT INFORMATION

ARE YOU A HURRICANE KATRINA EVACUEE? ☐ **YES** ☐ **NO**

Do you need help paying for health care in any of the previous three months, for any member of your household?

☐ Yes ☐ No If you checked "Yes", complete the Request for Medicaid Backdating form (HCF 10100B) found in this application packet.

Is anyone in your household blind, disabled or incapacitated? ☐ Yes ☐ No

Check the language in which you want your notices printed. ☐ English ☐ Spanish

What language is spoken in your home?

Case Number	Date Received

The following section should be completed with the information for the person that is applying for assistance.

Name of person applying (Last, First, MI)	Telephone Number (including area code)

Address (street, city, state, zip code)	Mailing address only if different from your residence.

List the names of your children who are under 18 years of age, who do not attend school full time.

SECTION II – GENERAL INFORMATION

List the names and requested information of all people living in your household (example: yourself, spouse, father, mother, children stepchildren, etc.). See page 1 of the application packet for marital and ethnic/race codes.

Providing or applying for a Social Security Number (SSN) is voluntary; however any person who wants Wisconsin Medicaid, BadgerCare or Family Planning Waiver, but does not want to provide their SSN or apply for one will not be eligible for benefits, pursuant to Wisconsin Statutes section 49.82(2).

Name (Last, First, MI)	Applying for Medicaid or BadgerCare ☐ Yes ☐ No	Applying for Family Planning Waiver Program ☐ Yes ☐ No	Social Security Number (Applicant Only)

Date of birth (MM/DD/YY)	Gender ☐ M ☐ F	Marital status Code	U.S citizen (Applicant Only) ☐ Yes ☐ No	Race or ethnic code (optional)	Relationship to applicant	*Has paternity been established? ☐ Yes ☐ No

Name (Last, First, MI)	Applying for Medicaid or BadgerCare ☐ Yes ☐ No	Applying for Family Planning Waiver Program ☐ Yes ☐ No	Social Security Number (Applicant Only)

Date of birth (MM/DD/YY)	Gender ☐ M ☐ F	Marital status Code	U.S citizen (Applicant Only) ☐ Yes ☐ No	Race or ethnic code (optional)	Relationship to applicant	*Has paternity been established? ☐ Yes ☐ No

Name (Last, First, MI)	Applying for Medicaid or BadgerCare ☐ Yes ☐ No	Applying for Family Planning Waiver Program ☐ Yes ☐ No	Social Security Number (Applicant Only)

Date of birth (MM/DD/YY)	Gender ☐ M ☐ F	Marital status Code	U.S citizen (Applicant Only) ☐ Yes ☐ No	Race or ethnic code (optional)	Relationship to applicant	*Has paternity been established? ☐ Yes ☐ No

*Complete only if the parents of this child were not married at the time of the child's birth. Check "Yes" if paternity has been established by a court action, or "No" if it has not.

WISCONSIN FAMILY MEDICAID / BADGERCARE APPLICATION
HCF 10100 (Rev. 06/05)

APP

Name (Last, First, MI)				Applying for Medicaid or BadgerCare ☐ Yes ☐ No	Applying for Family Planning Waiver Program ☐ Yes ☐ No	Social Security Number (Applicant Only)
Date of birth (MM/DD/YY)	Gender ☐ M ☐ F	Marital status Code	U.S citizen (Applicant Only) ☐ Yes ☐ No	Race or ethnic code (optional)	Relationship to applicant	*Has paternity been established? ☐ Yes ☐ No

SECTION III PREGNANCY

Is any member of your household pregnant? ☐ Yes ☐ No

If you answered "Yes", complete the rest of this section for the pregnant women in your household. You will need to provide verification from a medical professional of the pregnancy and the due date to your local county/tribal social or human service agency.

Name of pregnant woman	Due date	Are multiple births expected? ☐ Yes ☐ No	Number of babies expected
		☐ Yes ☐ No	

SECTION IV– ABSENT PARENT INFORMATION

If there is a reason that you do not want to provide information for an absent parent, leave this section blank. You will be contacted by your local county/tribal social or human service agency for additional information. If you are a woman between the ages of 15 and 18 and applying only for the Family Planning Waiver Program for yourself, leave this section blank

Do any children (including unborn children) have a natural or adoptive mother or father who is not living at home? ☐ Yes ☐ No

What is the name of the absent parent? (Last, First, MI)	What is the child's name? (Write in "Unborn" if the child has not been born.)

SECTION V – EMPLOYMENT

Are you or any household member working? ☐ Yes ☐ No

Is anyone listed below a migrant worker? ☐ Yes ☐ No

Complete the following for each member in your household (including yourself) who is employed.

Name of working person (Last, First, MI)	Employer's name, address and telephone number
Date employment began (MM/DD/YY)	
Gross monthly earnings this month (before taxes and deductions)	
Gross monthly earnings next month (before taxes and deductions)	

Name of working person (Last, First, MI)	Employer's name, address and telephone number
Date employment began(MM/DD/YY)	
Gross monthly earnings this month (before taxes and deductions)	
Gross monthly earnings next month (before taxes and deductions)	

SECTION VI – SELF-EMPLOYMENT

Are you or any household member self-employed? ☐ Yes ☐ No

If you answered "Yes", complete the rest of this section. List the amounts you reported to the IRS on your tax form. If you did not file taxes last year, leave the net annual income and depreciation boxes empty. If you leave these blank, your local county/tribal social or human services agency will contact you for more information.

Name of self-employed person (Last, First, MI)	Name and address of business
Net annual income $	
Depreciation amount claimed $	
List the amount of net annual income (before taxes and deductions) that you expect to earn this year $	Type of business

Name of self-employed person (Last, First, MI)	Name and address of business
Net annual income $	
Depreciation amount claimed $	
List the amount of net annual income (before taxes and deductions) that you expect to earn this year $	Type of business

SECTION VII – UNEARNED INCOME

Types of unearned income includes Social Security, Supplemental Security Income (SSI), Maintenance, Child Support, Worker's Compensation, Unemployment Compensation, Disability or Sick Pay, Interest or Dividends, Veterans Benefits, etc.

Does anyone in your household receive unearned income? ☐ Yes ☐ No

If you answered "Yes", complete the rest of this section for each person who receives unearned income.

Type of income	Name (Last, First, MI)	Gross monthly amount

SECTION VIII – INSURANCE

In the current month or in the last 18 months, have you or any employed person in your household been eligible to apply for any family coverage under an employer-provided major medical plan for which your employer contributed at least 80% of the premium?

☐ Yes ☐ No If "Yes", which family member(s) could have been insured under this health plan?

Family Members' Name:

In the next 12 months, will you or any member of your household be able to enroll in an employer-provided major medical plan at your current employer?

☐ Yes ☐ No If "Yes", which family member(s) can be insured under this health plan?

Family Member's Name:

If "Yes", what is the date you will be able to enroll?	If "Yes", what is the date coverage will begin?

Does any person have medical / health insurance coverage now, or in the previous three months? ☐ Yes ☐ No

Name and address of insurance company	Policyholder's name	
	Policy number	
	Date began	Date ended
	Who is covered under this policy?	

SECTION IX – CHILD CARE

Does anyone pay for child or adult care so they can work, look for work, go to school or receive training? ☐ Yes ☐ No

If you answered "Yes", complete the rest of this section for the person who pays for the care.

Name of person who pays for the care	For whom is this care provided?	
Name of person providing the care	Does this person live in your household? ☐ Yes ☐ No	Monthly amount $

SECTION X – CHILD SUPPORT

Does anyone pay child support? ☐ Yes ☐ No

If you answered "Yes", complete the rest of this section for the person in your household who pays child support.

Who pays child support?	Who receives the child support payments?	Monthly amount $
		$

SECTION XI – RIGHTS AND RESPONSIBILITIES

Your signature on the application means that you understand and acknowledge that the county/tribal social or human services agency and the state Department of Health and Family Services is authorized to request any information that is appropriate and necessary for the proper administration of Wisconsin Medicaid, BadgerCare and the Family Planning Waiver Program authorized under Wisconsin law.

You have the right to appeal any action taken concerning your Medicaid, BadgerCare or Family Planning Waiver Program application or on-going benefits that you do not agree with by requesting a Fair Hearing. You may request a Fair Hearing by writing to:

Wisconsin Department of Administration
Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

Or by calling: Telephone (608) 266-7709

The "Request for Fair Hearing" form can also be found on the Division of Hearings and Appeals web site at http://dha.state.wi.us/home/.

You may also contact the office where you applied and ask for assistance with filing a Fair Hearing request. You can also refer to the *Wisconsin Medicaid Program – Eligibility and Benefits* brochure (PHC 10025) or your Notice of Decision for more information on the fair hearing process.

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To file a complaint of discrimination contact either the:

Wisconsin Department of Health and Family Services (DHFS)
Affirmative Action and Civil Rights Compliance Office
1 W. Wilson, Room 555
Madison, WI 53707-7850
Telephone: (608) 266-9372 (Voice); (608) 266-5555 (TTY)
Fax: (608) 267-2147

OR

U.S. Department of Health and Human Services
Office for Civil Rights – Region V
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601
Telephone: (312) 886-5077 (voice) or (312) 353-5693 (TTY)

I have read my rights and responsibilities and I understand the questions and statements on this application form. I understand the penalties for giving false information or breaking the rules. I certify, under penalty of false swearing, that all my answers are correct and complete to the best of my knowledge, including information provided about the citizenship status of each household member applying for benefits. I understand and agree to provide documents to prove what I have said. I understand that the agency may contact other persons or organizations to obtain the necessary proof of my eligibility and level of benefits.

SIGNATURE – Applicant or Authorized Representative	Date signed

Did you use the ACCESS online screening tool prior to applying? ☐ Yes ☐ No
NOTE: The ACCESS online screening tool is optional. You **do not** have to use the tool prior to applying for Wisconsin Medicaid. See page 4 of the instructions for more information about ACCESS.

STATE OF WISCONSIN
DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Eligibility
HCF 10100B (Rev. 12/04)

APP

REQUEST FOR MEDICAID BACKDATED COVERAGE

If you are found eligible for Medicaid, you may be able to get Medicaid benefits for up to three months before your application date if all the needed information is collected for the prior months and you are determined to have been eligible in those months. If you want help paying for health care for any of the three months before your application date (backdated coverage), make sure you checked the "Yes" box on the application where this question is asked and complete this form.

If there are any differences in circumstances in any of the three months before your application month list the differences below for each month that you are requesting backdated coverage. Differences may include: address, household composition, income, assets (only if someone in your household is 65 years of age or older, blind or disabled), vehicles, insurance.

Month 1 will be the earliest month that you could be found eligible. Example, if you applied in June, your application month is June. If you have medical bills in March and want backdated coverage to March, then March is month 1, April is month 2, and May is month 3. Complete the following questions for each month that you have medical bills and want backdated coverage.

Month 1

Are you requesting backdated coverage for this month? ☐ Yes ☐ No
Is any information included in your application different in this month from the application month? ☐ Yes ☐ No If "Yes", describe the changes.

Month 2

Are you requesting backdated coverage for this month? ☐ Yes ☐ No
Is any information included in your application different in this month from the application month? ☐ Yes ☐ No If "Yes", describe the changes.

Month 3

Are you requesting backdated coverage for this month? ☐ Yes ☐ No
Is any information included in your application different in this month from the application month? ☐ Yes ☐ No If "Yes", describe the changes.

SIGNATURE – Applicant	Date Signed

STATE OF WISCONSIN
DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 10137 (Rev. 12/04)

CHG

MEDICAID CHANGE REPORT

If you are receiving Medicaid, you must report any changes in your household composition (if anyone moves in or out of your household, if anyone gets married, becomes pregnant, or gives birth to a child), address, income, assets (only people age 65 or older, blind or disabled) or employment status **within ten days**. If such a change has occurred, fill out this report and mail it or take it to the office shown in the box below, or contact your worker by telephone or in person about any changes. If this report does not provide enough room to document a change, attach a sheet of paper with the additional information written on it to this report.

(County agency address)

Your Name	Case Number	Worker Name

If you intentionally fail to report any changes or provide false information, you may be fined, have to pay back any Medicaid benefits you wrongfully received, be prosecuted, or all three. You may be required to provide proof of any changes you report.

SECTION I - CHANGE IN ADDRESS

If you move, you must report your new address.

Date of change	New telephone number

New address (street, city, state, zip code)

SECTION II - CHANGE IN HOUSEHOLD COMPOSITION

You must report if anyone moves in or out of your household, if anyone gets married, becomes pregnant, or gives birth to a baby (include information about the person who gave birth and the newborn.)

Name(s) (Last, First, MI)	Date of change

Social Security Number (SSN)*	Date of birth	Relationship to Case Head

Describe the change

*Providing or applying for an SSN is voluntary; however any person who wants Wisconsin Medicaid but does not want to provide their SSN or apply for one will not be eligible for benefits, pursuant to Wisconsin Statutes section 49.82(2).

SECTION III - CHANGE IN INCOME

You must report a change in your gross income amount, a new source of income, changes in your employment status (part-time to full-time or full-time to part-time, loss of employment), changes in salary or rate of pay, changes in the amount of Social Security, Veterans benefits, Unemployment Insurance, Worker's Compensation, or any other change in the amount of money your household receives.

Name (Last, First, MI)	Date income changed

Source of income	Monthly amount	How often Paid

SECTION IV - CHANGE IN ASSETS

Those who are elderly, blind or disabled must report changes in their cash, bank accounts, bonds, stocks, vehicles or other assets.

Name of owner (Last, First, MI)		Date of change

Type of asset	Describe the change	New value or amount $

Name of owner (Last, First, MI)		Date of change

Type of asset	Describe the change	New value or amount $

SECTION V – CHANGE IN VEHICLES

Report if you obtain, sell or give away a car, truck, motorcycle, boat, snowmobile, camper, or another type of vehicle.

Name of owner (last, first, MI)					Date of change

Type of vehicle	Make	Model	Year	Amount received $	Describe change (bought, sold, etc.)

SECTION VI - OTHER CHANGES

Report any other changes that you believe may affect your Medicaid eligibility. Examples of other changes include someone getting or dropping health insurance or someone becoming disabled or recovering from a disability. Include the date of any other change.

Describe change

Do you expect that the changes reported on this form will remain the same next month? ☐ Yes ☐ No

If No, explain.

SECTION VII – SIGNATURE

I understand that there are penalties for hiding information or giving false information. I also understand that I may have to pay back any benefits I receive because I do not fully report changes in my circumstances. I agree to provide proof of any changes, if asked to do so. My answers on this form are correct and complete to the best of my knowledge.

SIGNATURE – Participant	Date signed	Telephone number

RETAIN COMPLETED FORM IN CASE FILE (FOR AGENCY USE ONLY)